

**Literature Review on Quality of Care  
and Willingness to Pay for  
Family Planning or Health Services**

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**LITERATURE REVIEW ON QUALITY OF CARE AND  
WILLINGNESS TO PAY FOR FAMILY PLANNING OR HEALTH SERVICES**

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<b>Author, Title, Activity Level and Type</b>	<b>Nature of Intervention</b>	<b>Findings</b>
<p>Wouters, A.</p> <p>"Improving quality through cost recovery in Niger." <i>Health Policy and Planning</i>, v. 10, no. 3 (1995): p. 257-270.</p> <p>Non-hospital facilities; project intervention.</p>	<p>In Niger, the role of improvements in the quality of health care in the context of health care financing reforms and cost recovery was explored in a 1993 pilot project. The project 1) supported drug availability by training health workers in diagnostic/treatment protocols using generic brands, 2) improved management systems and capabilities related to fee collection, and 3) installed systems for mobilizing additional resources at non-hospital facilities. Data on quality of care were collected using an evaluation of the cost recovery tests and through surveys of facilities and patients. In this study, quality of care was defined as the proper performance of safe, affordable, and effective interventions. This performance was measured at the structural, process, and outcome levels.</p>	<p>Although implementation of the pilot program led to improvements in structural attributes of quality, significant gaps remained in the implementation of diagnostic and treatment protocols. The quality improvements put in place required significant investments in fixed and variable costs, and it is unlikely that optimal cost-effectiveness of services was achieved. In the test site of Boboye, copayment revenues covered 34% of the costs of medicines or 20% of the costs of drugs and cost recovery administration. In Say, user fees covered 50-55% of the costs of medicines (35-40% of drugs and administration). In Boboye, user fees plus additional taxes and copayments covered 120-180% of the cost of medicines (75-105% of drugs and administration). In-service training and other aspects of quality improvement were not covered. The sustainability of quality improvements rests with whether funds collected are rechanneled to pay for continued improvements.</p>
<p>Akin, JS; Guilkey DK; Denton EH.</p> <p>"Quality of services and demand for health care in Nigeria: a multinomial probit estimation." <i>Social Science and Medicine</i>, v. 40, no. 1 (1995): p. 1527-37.</p> <p>Health facilities; population sample data.</p>	<p>The authors attempt to empirically determine for a population sample from Ogun State, Nigeria, whether price increases for health care lead to large reductions of care usage or to shifts across types of care used; whether price increases lead to net increases in revenues for the health system; and if price increases have larger impacts in the form of reductions in health care usage upon lower income members of the population. Household data are combined with data on prices and quality of care, collected directly from facilities, to estimate the demand for outpatient health care.</p>	<p>After trying several health care provider quality variables, they settled upon the following which were statistically significant: expenditure per person in population served, percentage of time drugs are available, and interviewer's evaluation of the physical condition of the facility. Price of a visit to the facility is also included, as is an exogenous variable collected directly from the alternative available providers. It is determined that higher prices at either type of facility will tend to reduce usage of that type, and that usage will tend to increase for each type of care as the quality of care is increased. The results also indicate no difference in the price responsiveness of different income groups.</p>

<p>Hotchkiss, D.</p> <p>"The role of quality in the demand for health care, Cebu, Philippines." Abt Associates, Health Financing and Sustainability Project, USAID. Dec. 1993. PN-ABS-913.</p> <p>Public health facilities; mixed multinomial logit model of survey data.</p>	<p>The Health Financing and Sustainability Project applied data from the Cebu Longitudinal Health and Nutrition Study to a mixed multinomial logit model to estimate the effects of quality, price, distance, and individual characteristics on the choice of obstetric care provider in a developing country. The data were collected from households and health care facilities. The obstetric care alternatives in Cebu, Philippines, ranged from home childbirth assisted by friends and relatives to modern, private hospitals. The reduced-form model estimated specifications include price, travel time, and various combinations of quality measures (availability of medical supplies, practitioner training, service availability, facility size, and crowdedness) and their interaction with individual characteristics (assets, household structure, educational attainment, food prices, and health insurance).</p>	<p>The significant determinants of consumer choice were facility crowding (negative effect, <math>p &lt; 0.05</math>) and practitioner training in childbirth (positive effect, <math>p &lt; 0.01</math>). Education of the woman and other individual characteristics interact significantly with quality in affecting choice. For example, availability of drugs has a significant effect on facility choice for well-educated women only. Poor households were more sensitive to higher user fees than others. The computer simulations revealed that, when public facilities increase user fees at the same time as they improve the aspects of quality over which policymakers can wield control in the short run, the mean probability of utilization of public facilities increases for both poor and nonpoor households.</p>
<p>Weaver, M., et al.</p> <p>"Estimating the willingness to pay for quality of care: comparison of contingent valuation and two-step health expenditure methods." Abt Associates, Health Financing and Sustainability Project, USAID. Oct. 1993. PN-ABW-484.</p> <p>Public health facilities; contingent valuation questions and the 2-step health care expenditure model</p>	<p>The issue of how a combination of user fees and quality improvements will affect the utilization of public health facilities was addressed through a study which used contingent valuation questions to collect information on demand for a higher level of service quality and the 2-step health care expenditure model to estimate the probability that an ill person had expenditures for modern health care and to estimate expenditures.</p>	<p>Medium willingness to pay for the following quality improvements was documented: 1) facility maintenance; 2) personnel supervision; and 3) pharmaceuticals to treat malaria, sexually transmitted diseases, acute respiratory infections, intestinal parasites, and diarrheal diseases. It was found that the median willingness to pay is higher than the estimated cost for each quality improvement. Both assessment methods provided valid and reliable estimates of willingness to pay for pharmaceuticals but not for facility maintenance or knowledge of personnel. However, further research is recommended to compare the methods and to increase our understanding of the relationship between user fees and quality of care. If researchers can use only a single method, the contingent valuation method is recommended as being easier to tailor to a specific quality improvement for a specific project and because it is less expensive, although it does have higher design costs than the 2-step health expenditure method.</p>

<p>Wouters, A.; Adeyi O.; Morrow R.</p> <p>"Quality of health care and its role in cost recovery with a focus on empirical findings about willingness to pay for quality improvements. Phase I: Review of concepts and literature, and preliminary field work design." Abt Associates, Health Financing and Sustainability Project, USAID. Dec. 1993. PN-ABW-475.</p> <p>Literature review of facility based studies.</p>	<p>As the first phase of USAID-sponsored research on the relationship of quality improvements to cost recovery schemes in the health sector, this report provides an in-depth literature review of 5 major topics: 1) facility-based studies of the effect of cost recovery on utilization, 2) econometric health care demand studies, 3) hedonic pricing studies, 4) contingent valuation surveys, and 5) cost-recovery intervention studies.</p>	<p>After a chapter devoted to conclusions reached both in general and from evaluation of each type of study, the report offers a preliminary design of field research activities with details on a possible research objective, literature review, the study site, intervention, a general hypothesis (stated as null), the study design, sample size, analysis information, management, and evaluation.</p>
<p>Attah, EB; Plange, NK</p> <p>"Quality of health care in relation to cost recovery in Fiji: focus group study report." Abt Associates, Health Financing and Sustainability Project, USAID. Oct. 1993. PN-ABS-911.</p> <p>Public sector health services, hospital and clinic; focus group study.</p>	<p>The purpose of this study was to carry out a rapid appraisal of consumer preferences for quality improvements in health services in Fiji, particularly in the public sector, and of consumers' willingness to pay for these improvements. These findings would contribute to the discussion of alternative cost recovery mechanisms to be incorporated into the policy reforms of the Ministry of Health. Four focus group sessions were conducted with in- and outpatients at the Colonial War Memorial Hospital and the Suva Health Clinic, four with members of the general public, and one with a group of medical students. The topics discussed included how consumers view quality in choosing care; what indicators they use to evaluate quality; what importance they attach to the various indicators; under what conditions they bypass nearer clinics to go directly to the hospital; what quality improvements they want; would their use of government facilities increase if quality were improved; and how much extra would they pay for those improvements.</p>	<p>It was found that clients believed the whole health care system to require an overhaul, and their first response to illness was self-treatment. Consumers used the hospital first for serious conditions, and consulted private practitioners first in other cases, often being referred to the hospital for tests. The most important quality indicator was the art of care, followed by availability of drugs and of relevant personnel. Technical quality of care and of the physical environment were lesser concerns, and accessibility was the least important. The consumers generally by-pass clinics in favor of hospitals, but would increase use of government facilities if improvements were made. The consumers would also pay for the improvements they recommended on a sliding-scale basis. They were not receptive to user fees without improvements. Based on these findings, recommendations were made for immediate, intermediate, and long-term actions to improve the quality of health care on Fiji.</p>

<p>Tsongo, B., et al.</p> <p>"Cost recovery and quality of care in the Congo." Abt Associates, Health Financing and Sustainability Project, USAID. Sep. 1993. PN-ABS-912.</p> <p>Public and private health facilities; patient interviews.</p>	<p>A study was undertaken in the Congo in the summer of 1992 to examine the relationship between quality of services (from the patients' perspectives) and fee systems in public and private health facilities and in rural and urban areas and to analyze patient characteristics in conjunction with choice of a facility. The working hypothesis was that private facilities can charge higher fees because they are perceived as providing higher quality services. Data were collected from exit interviews with 399 out-patients at 8 health centers evenly divided among rural, urban, private, and public. Information was elicited on patient characteristics, curative care, satisfaction, and payment.</p>	<p>It was found that the patients shared similar characteristics, except that the age, likelihood of being married, and average household expenditures were higher for public patients. The reported patient satisfaction was higher in private facilities where the availability of medicines was greater (50% of patients received medication compared to 20% of public patients). 78% of private patients versus 31% of public patients paid for their services, and public patients paid higher prices for drugs. There were more nonpaying patients at public facilities, including respondents in the higher socioeconomic range. However, many low income patients at both types of facilities did not pay a fee. In addition, it was found that although there were urban/rural differences in patient characteristics, the characteristics of public/private patients within a geographic category were similar. Among paying patients, the average fee paid was higher in public facilities in urban areas. In rural areas, the average fee paid was higher in private facilities. These results suggest that the government may be able to improve the quality of public services by improving the drug supplies and that consumers are willing and able to pay more for what they perceive as higher quality care.</p>
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<p>Anonymous</p> <p>"Quality care for community-based FP/MCH." <i>JOICFP News</i>, Feb. 1995, p. 1.</p> <p>Community-based project; workshop.</p>	<p>The Regional Workshop on Quality Care for Community-based FP/MCH in Asia was organized by the Family Planning Association of Nepal (FPAN) in cooperation with JOICFP and held in Kathmandu, Nepal, December 4-9. Representatives of counterpart organizations in Bangladesh, Laos, Nepal, and the Philippines implementing the UNFPA-supported Sustainable Community-based FP/MCH Project with Special Focus on Women were included among the forty participants. Representatives of China and Vietnam as well as resource persons from Mexico and Japan also attended the event. The workshop was held with the goal of providing participants with effective strategies for promoting quality care for community-based FP/MCH activities based upon the Nepalese experience. The event also provided the opportunity for participants to share experiences, develop strategies for project sustainability, and identify strategies and action plans suitable for their particular country situations.</p>	<p>In field trips to Panchkhal, Sunsari, and Morang where the project is being implemented in 26 villages, participants noted the strong community involvement and village leader support. They were also impressed by the communities' awareness of services provided under the project. FPAN has succeeded despite geographical and cultural difficulties in promoting fee-based services toward project sustainability. By paying nominal fees, villagers also enjoy access to drugs and services which may not have been available through the government free of charge. Participants at the end of the workshop recommended the identification of specific indicators and systems for monitoring services and activities, training and orientation at all levels to improve the skills and attitudes of health care workers, the development of potential income-generating activities, the provision of essential FP/MCH equipment, and the equal involvement of men and women at the policy and implementation levels.</p>
<p>Anonymous</p> <p>"People readily pay for quality services in Nepal." <i>JOICFP News</i>, Dec. 1994, p. 6.</p> <p>Community-based project; monitoring report.</p>	<p>A monitoring mission found that the UNFPA-supported Sustainable Community-based Family Planning/Maternal and Child Health (FP/MCH) Project with Special Focus on Women has been expanded in Nepal to meet grassroots demands and is being fully supported by the community people. The project, which is being implemented by the Family Planning Association of Nepal (FPAN), provides health services on a fee-charged basis.</p>	<p>Community people are charged 75% of the total cost of services and medicines as a means to promote sustainability. The project has been integrated into FPAN's strategic plan of promoting community participation, women's involvement, accessibility, sustainability, and quality care. Under the project, mobile teams of health professionals visit villages twice monthly to provide FP/MCH and health care services. Mother's clubs with family planning (FP) acceptors have been established in all wards of the project village. Acceptors are targeted to receive FP training to become reliable sources of information on FP for other women in the village.</p>

<p>Lavy, V; Germain JM</p> <p>"Quality and cost in health care choice in developing countries." World Bank, 1994.</p> <p>Health facilities; survey data.</p>	<p>Data from the Ghana 1988-89 Living Standard Survey on 6000 individuals from 88 clusters (2150 with an illness or injury) and a 1989 health facility survey were used to model, theoretically and empirically, the effect of quality of health care on demand and choice of treatment. The simultaneous influence of travel costs and user fees and quality of options on the choice between health care options was examined. Variables were access to health care (distance), price of health care, quality, and the level of schooling of heads of households. The estimated model was used to simulate the impact on health choices and demand when improving quality of drugs and service availability, qualified personnel, adequate equipment, and reduced distance, and increased or decreased user fees. Calculations were also made for the amount households were willing to pay for improvements in accessibility and quality of public health services. The demand model used a more general function and treated cost of time in travel and waiting for treatment as facility-fixed effects. Decisions about choice of health care or whether to seek medical care were based on maximizing utility.</p>	<p>A discrete choice model for choice of provider was chosen. The conditional utility function, health production function, and distributions of stochastic variables were specified, and the probability was derived for choosing a given alternative, which was then used to estimate the utility function through a maximum likelihood procedure. Variables included availability of specific drugs, number of doctors and nurses, medical facility with electricity and running water, availability of immunization and other services, an operating room, distance of facility, visit cost, government employment of the head of household, income, years of schooling, gender, head of household's schooling. Results were discussed according to estimation results, the probability of using health care under different policies, and willingness to pay. Distance was an important deterring factor in seeking modern health care, and prices were less important. Demand for health care was affected more strongly by improved basic services than by facility infrastructure. Almost 1% of monthly income would be paid for improvements in drug/service availability, but payment would be higher for improved access.</p>
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<p>Litvack JI; Bodart C.</p> <p>"User fees plus quality equals improved access to health care: results of a field experiment in Cameroon." <i>Social Science and Medicine</i>, v. 37, no. 3 (1993): p. 369-383.</p> <p>Public health facilities; pre-test, post-test survey experiment.</p>	<p>Since the Bamako initiative was launched in 1988, many African countries have embarked on comprehensive primary health care programs relying, at least partially, on revenues generated through user fees to revitalize health care delivery systems. Although these programs contain 2 critical components, user fees and improved quality, policy debates have tended to focus on the former and disregarded the latter. The purpose of this study is to provide a net assessment of these 2 components by testing how user fees and improved quality affect health facility utilization among the overall population and specifically among the poorest people. A pretest-posttest controlled experiment was conducted in 5 public health facilities in the Adamaoua province of Cameroon. 3 health centers which were to introduce a user fee and quality improvement (i.e, reliable drug supply) policy were selected as treatment centers and 2 comparable facilities not yet phased into this policy were selected as controls. 2 rounds of household surveys were conducted (each to 800 households in 25 villages surrounding the 5 study sites) to measure the percentage of ill people seeking care at the health center before and after the implementation of the policy. The experiment was tightly controlled by conducted monthly observations at each study site.</p>	<p>Results indicate that the probability of using the health center increased significantly for people in the treatment areas compared to those in the control areas. Travel and time costs involved in seeking alternative sources of care are high; when good quality drugs became available at the local health center, the fee charged for care and treatment represented an effective reduction in the price of care and thus utilization rose. Moreover, contrary to previous studies which have found that the poorest quintile is most hurt by user fees, this study found that probability of the poorest quintile seeking care increases at a rate proportionately greater than the rest of the population. Since the poor are most responsive to price changes, they appear to be benefiting from local availability of drugs more than other. (author's abstract)</p>
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<p>Jain, A; Bruce J.</p> <p>"Quality: the key to success."  <i>People</i>, v. 16, no. 4 (1989): p. 6-8.</p> <p>Overview piece.</p>	<p>The empirical information that links quality of care elements with clients' knowledge, satisfaction, contraceptive use, fertility and health--though limited--strongly suggests that improvements in the quality of services will result in a larger, more committed clientele of satisfied contraceptive users. Over the long term, this expanded base of well-served individuals will translate into higher contraceptive prevalence and, ultimately, reduction in fertility.</p>	<p>Within private and commercial programs, where clients provide all or partial cost recovery, the laws of the marketplace suggest that better services at the right price will attract more patrons. Within publicly supported programs, both clinic and community-based, it is likely that improvements in the quality of services will result in greater initial acceptance and more sustained use. The proposition that providing a choice of methods increases the effectiveness of family planning programs is based on the following 3 ideas: 1) that individuals and couples pass through different stages in their reproductive life and therefore over time their needs and values will change; 2) that multiple methods provide for switching for individuals who find their initial choice unacceptable or unhealthful; and 3) that the availability of a variety of methods makes it more likely that--given erratic contraceptive supplies--at least services for some method will be available. (author's modified)</p>
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<p>Anonymous</p> <p>"Providing quality family planning and MCH services in the urban areas: the YKB experience." <i>JOICFP Review</i>, Jun. 1986, p. 18-22.</p> <p>Urban clinics; project review.</p>	<p>In Indonesia, the provision of family planning services to the community for a fee through a privately operated clinic is a relatively new concept. The idea to charge patients for family planning services came up during several meetings sponsored by the National Family Planning Coordinating Board (NFPCB) in its effort to increase family planning acceptance in urban areas. NFPCB realized that while the village family planning program was very effective, the urban family planning program was lagging behind for several reasons: while its services were free, most government-run clinics were open only in the morning, making it inconvenient for working mothers to avail themselves of the services; government operated clinics were crowded; since the services were free, they were perceived to be not of good quality; and there was a limited range of contraceptives and drugs available in the government operated clinics. In 1980, the Yayasan Kusuma Buana (YKB), a private nonprofit health and family planning organization in Jakarta, was asked by the Badan Koordinasi Keluarga Berencana Nasional (BKKBN) to set up a semi-commercial, urban family planning clinic as a pilot project. The clinic was established in an area where most of the residents belonged to the lower middle income group.</p>	<p>After almost 3 years, the clinic became self-reliant and was used by the YKB as a basis for expanding the project. Currently, there are 9 such clinics in Jakarta and YKB is helping 10 other Indonesian cities to set up their own clinics. This paper considers the main components of YKB's strategy for planning and managing the clinic and provides an analysis of the YKB experience in operating a successful family planning and maternal and child health program in the urban areas. To become self-reliant and at the same time have a successful family planning and health program, clinics should have the following characteristics: integrated services; competent and attractive clinic personnel; a strategic location; longer clinic hours; and a reasonable fee structure. A variety of outreach activities have been found to be useful in generating community interest in the YKB clinics, including inviting mothers groups to hold their meetings on the clinic premises. Information/education/communication materials in the form of posters, leaflets, booklets, flipcharts, and magnetic boards are needed to support community outreach and promotional activities. Those who plan to undertake the creation of a private clinic should keep in mind the following points if success is to be realized: community outreach is critical; clinic services should be adapted to community needs; adequate staff training and support should be provided; services should be expanded; and ties with government organizations, medical organizations, and community groups should be established and maintained.</p>
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<p>Weaver, M., et al.</p> <p>"Willingness to pay for child survival: results of a national survey in Central African Republic. Technical Report." Unpublished. 1993.</p> <p>Public facilities; contingent valuation methods and measures of monthly household consumption.</p>	<p>The Ministry of Public Health and Social Affairs (MPHSA) in Central African Republic has an award-winning Child Survival Program which includes treatment for diarrheal diseases and malaria, and will soon include acute respiratory infections (ARI), sexually transmitted diseases (STD), and birth spacing. The MPHSA is designing a user fee program for public facilities in order to sustain program successes and finance quality improvements. Potential quality improvements include facility maintenance, the supervision of personnel, and drugs to treat malaria, STDs, ARI, intestinal parasites, and diarrheal diseases. This paper reports findings from a national survey conducted to assess the public's willingness and ability to pay for these improvements. Willingness was measured by contingent valuation and a comparison of current expenditures, while ability to pay was measured by willingness to pay as a percentage of monthly household consumption. Differences in willingness and ability to pay for health care were examined between urban and rural areas and across health regions. The survey was conducted in a nationally representative sample of 1263 households with 16 households selected from each of 79 census tracts.</p>	<p>The following conclusions were made: the user fee program has good prospects for financing the estimated costs of all of the proposed seven quality improvements, the median of current expenditures was less than the median of the contingent valuation measure of willingness to pay, the contingent valuation measure of willingness to pay was greater in rural areas than current expenditures, both measures of willingness to pay show that differences exist interregionally, and the population will be able to pay the estimated cost of the improvements.</p>
<p>McPake, B.</p> <p>"User charges for health services in developing countries: a review of the economic literature." <i>Social Science and Medicine</i>, v. 36, no. 11 (1993): p. 1397-405.</p> <p>Literature review.</p>	<p>Health services in many developing countries have long been provided free at the point of use. Faced with rising demand for services and contracting resources, a number of countries are, however, introducing or raising previously low user fees for services. Review of literature on the topic suggests that the efficiency of user charges for health services is theoretically related to the level of externality, the price elasticity of demand, the proportion of total costs which are private access costs, and the level of government budget constraints. Theoretical models predict that the price elasticity of demand for health services is likely to be higher for lower income groups and that user charges are therefore unlikely to promote equity in the utilization rates of the rich and poor.</p>	<p>Empirical evidence tends to confirm the latter prediction, but suggests that user charges in many countries offer the potential for welfare gains for the majority. This potential is seldom exploited in practice and only marginal successes have been had in collecting substantial revenues. Administrators tend to place the greatest emphasis on financial measures of program success. Greater emphasis should instead be placed upon improving program efficiency and overall service quality to best exploit the potential for majority gains.</p>

<p>Bitran, R.</p> <p>"Household demand for medical care in Santo Domingo, Dominican Republic." State University of New York at Stony Brook, Health Care Financing in Latin America and the Caribbean Research Report No. 9. Mar. 1989.</p> <p>Private and public health facilities; survey data and consumer behavior modeling.</p>	<p>This draft document presents workshop recommendations of health policymakers, academic and research institutions, and US and international organizations on the demand for medical care in Santo Domingo, Dominican Republic. The analysis and recommendations are based upon a model of consumer behavior developed to estimate the effects of explanatory variables on whether to seek medical care when ill, and which health subsector to use to get care. Explanatory variables examined for outpatient care include social security institute coverage, household income, sex, age, education, price of medical care, travel time to health facilities, and type of health problem. 1987 household survey data were employed from 11,565 member interviews of 2537 households. 42% of the studied population had symptoms of illness over the 2-week survey recall period, yet only 1/3 sought medical attention. Of those choosing to not seek help, 10-20% cited financial constraints. This report further discusses utilization patterns, determinants of demand, and the effects of price on demand.</p>	<p>Among those seeking care, strong preference existed for private health care, even among low-income families, the uninsured, and those eligible for care elsewhere. Patients therefore perceive private care to be superior to care in the public sector, and were willing to pay for it. Public health subsectors should make greater efforts to meet the treatment and service needs of the population. Specifically, clients could be screened to determine if they are eligible for insurance or treatment in alternative venues, a referral system should be developed, and ambulatory patient access to public hospitals restricted. Given the population's general willingness to pay for health services, officials should consider the possibilities of imposing more and/or steeper fees to more people and/or for a larger array of services. An experimental cost recovery project could be designed and implemented to this end. Finally, health officials should require more employers to provide employee health insurance benefits.</p>
<p>International Planned Parenthood Federation (IPPF).</p> <p>"Report of the Seminar on Programme Sustainability through Cost Recovery, Kuala Lumpur, Malaysia, 21-25 October, 1991. London, England. IPPF, 1995.</p> <p>Seminar results of shared country experience with cost recovery including willingness to pay.</p>	<p>In the face of widespread user acceptance, rapidly growing demand, and developing country financial constraints, family planning associations must learn how to operate more efficiently and mobilize new resources with a view to ensuring greater long-term sustainability. Cost recovery was therefore identified as a means of maximizing the use of limited resources, improving program quality, strengthening management, and making service providers more accountable to clients. This document reports results from seminar participants organized to share the benefits of cost recovery with the international community, and to review policy and management issues.</p>	<p>Reviewed in the seminar were country experiences with cost recovery, working group discussions on the definition of sustainability, the cost framework of family planning, determining user fees and clients' willingness to pay, preconditions for setting user fees, prerequisites for social marketing, models for cost sharing with the government and private sector, and country case studies from the Gambia, India, and Kenya. Those programs attaining highest self-sufficiency were aided by strong government commitment to either support family planning or to not impede program progress. Also helpful were a businesslike approach to service provision, a strong promotional campaign, organizational structure conducive to effective resource management, and resolve to try diverse approaches. In concluding, the importance of placing the customer first, cost-effectiveness, cost analysis, strategic planning, inter-FPA cooperation, and business plans are mentioned.</p>

<p>Vogel, RJ</p> <p>"Cost recovery in the health care sector: selected country studies in West Africa." World Bank, 1988.</p> <p>Public health services; evaluation.</p>	<p>The status of health financing in the West African countries of Senegal, Mali, Ivory Coast and Ghana, focusing on cost-recovery, resource allocation and health insurance plans, is evaluated. Health status remains the worst in the world in the area, aggravated by declining health budgets, deficiencies of supplies of drugs and equipment, longstanding inefficiency and misallocation of resources. Cost recovery in the form of user fees will provide additional resources, as well as solve some of the problems of efficiency and inequity. Cost recovery as it exists is not well administered, involving losses due to misappropriation and exemptions. Allocation of health funds at present is biased towards salaries and complex curative services in urban hospitals.</p>	<p>People are willing to pay for health care if they perceive it as an improvement in quality. Private health insurance plans barely exists. Limited public health insurance is a part of the Social Security System in Francophone countries, but these are poorly structured by actuarial standards. It is recommended that cost recovery be instituted, preceded by improvement in perceived quality of services, and accompanied by equitable and efficient allocation of services, beginning with fees for drugs and tertiary services.</p>
<p>Haddad S; Fournier P.</p> <p>"Quality, cost and utilization of health services in developing countries. A longitudinal study in Zaire." <i>Social Science and Medicine</i>, v. 40, no. 6 (1995): p. 743-53.</p> <p>Rural community public health service; longitudinal study.</p>	<p>Many developing countries, particularly in Africa, have recently introduced payment schedules based on the selling of essential drugs. This is one of the main elements of the Bamako Initiative according to which the income generated would ensure a reliable supply of drugs and would improve other aspects of the quality of the services offered. Thus, quality improvements would compensate for the financial barrier and as a result the utilization of public health services would be increased or at least maintained. These hypotheses have proven to be partially valid, since there have been cases where the utilization of health services has increased and others where it has decreased; these inconclusive results have fuelled criticisms concerning the inequitable nature of these measures.</p>	<p>This longitudinal study in a rural community of Zaire shows that the utilization of health services had diminished by close to 40% over 5 yr (1987-1991) and that 18-32% of this decrease is explained by cost. The regular supply of drugs and the improvement in the technical quality of the services--technical qualification of the staff, allocation of microscopes, and renovation of the infrastructures--was not enough to compensate for the additional financial barriers created by the increased cost of services. However, on a local level, the interpersonal qualities displayed by some of the nurses sometimes helped to compensate for the negative effects of the costs, and even to increase the level of utilization of some health centres. The quality of public services has often been neglected in developing countries. While some attention is given to technical qualities, the interpersonal components of the quality of the services are generally ignored or underestimated by planners and they are the very components which are most resistant to change. It will be a major challenge for health systems to address this issue of quality of care in order to minimize the negative impact of the introduction of user payment schemes. Therefore, now is the time to place quality next to coverage in planners' agendas.</p>

<p>Richardson, Paul; Galloway, Jack; et al</p> <p>"Quality, costs and cost recovery : a comparative study of the Unidad Sanitaria of the Ministry of Health (MOH) and PROSALUD in Santa Cruz, Bolivia." USAID Mission to Bolivia, La Paz, Sep 1992, iii, 70 p. PN-ABN-015.</p> <p>Primary health care delivery</p>	<p>The purpose of this study is to assist the Ministry of Health (MOH)/Unidad Sanitaria de Santa Cruz to better understand the strengths and weaknesses of its primary health care delivery system in the city of Santa Cruz and to make recommendations for improving the system and ultimately the health care services provided to MOH clients. In order to identify specific problems and possible solutions, the Unidad Sanitaria suggested that this study analyze the strengths and weaknesses of both the MOH health care system and the PROSALUD private non-profit health care system operating in Santa Cruz. The analysis focused on two MOH and two PROSALUD health centers looking at recurrent costs at the facility level, in-depth interviews of health center and headquarters staff, observation of technical service delivery, focus groups of patients and survey of patients.</p>	<p>Summary of findings: PROSALUD is spending at higher levels in its urban centers than is the MOH; unit costs are considerably higher in the MOH; PROSALUD has, for the most part, excellent operational systems, while the Ministry's systems are average to poor; technical quality of direct provider care, as measured by observation, is similar in the two systems; <b>quality of care as perceived by patients is better in PROSALUD than in MOH facilities; patient satisfaction is higher with PROSALUD than with the MOH; utilization and cost recovery is much higher in PROSALUD than in the MOH.</b></p>
<p>Lavy, Victor; Germain, Jean-Marc</p> <p>"Quality and cost in health care choice in developing countries." World Bank, 1994.</p>	<p>The definition of health care quality and the impact of improved quality on the demand for health care have not been the subject of rigorous econometric studies. This study models theoretically and empirically the quality of health care in household decision making with respect to demand for health care and presents empirical evidence concerning the impact of various policy options on these decisions. Besides modeling quality explicitly, the model relaxes some of the restrictive assumptions that were common in recent studies of the demand for health care.</p>	

<p>Lavy, Victor; Quigley, John M.</p> <p>"Willingness to pay for the quality and intensity of medical care: low-income households in Ghana." World Bank, 1993.</p>	<p>Important choices about the organization of health care systems and the role of government in the provision of health care depend crucially upon citizen demand for health services as well as the efficiency of those services in promoting the well-being of citizens. In the context of developing countries, where available public resources are scarce, credible estimates of the private value of subsidized treatment are needed to establish priorities for public budgeting. This paper estimates the elements affecting the choice among different kinds and intensities of medical treatment in response to illness or injury. The authors also estimate households' willingness to pay for medical care.</p>	<p>In the empirical analysis, particular attention is paid to three important theoretical and measurement issues: 1) the decision to seek medical treatment and the intensity of treatment sought is responsive to an ex-ante evaluation of the seriousness of the illness or injury, not to some outcome of the treatment measured ex post; 2) the decision to seek treatment includes qualitative and quantitative dimensions; and 3) the cost of medical services is borne by consumers in highly complex ways, depending upon the facility chosen, the number of consultations or treatments sought, the seriousness of the illness or injury, and government policy for subsidy or insurance.</p> <p>The data used for this analysis are well suited to address the difficulty of drawing inferences about these complex measurement issues in consumer choices. The analysis is conducted using cross sectional data on the behavior of Ghanaian households -- typically low income households -- in response to illness or injury. The empirical analysis is based upon the choices of 5,000 individuals in 1987.</p>
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